

## **Introduction to South Dakota Medicaid Expansion Concept Paper**

**March, 2015**

Access to health care in South Dakota is limited by factors including geography and provider availability. South Dakota comprises almost 76,000 square miles with a very low population density of 10.7 persons per square mile. 57 of 66 counties are defined as primary care Health Care Professional Shortage Areas or sites, and 59 counties have Medically Underserved Areas. These access issues are even worse for Native Americans living in South Dakota. South Dakota Native Americans live in some of the poorest counties in the country, and access to local health care is limited. Health care disparities among South Dakota Native Americans are pronounced.

Eligible South Dakota Native Americans are served by the Great Plains Indian Health Service Unit. However, actual access to Indian Health Services is limited in all areas of the state, and IHS contract care budgets do not meet the demand for healthcare beyond even limited emergency services. As a result, **Native Americans eligible for IHS services use non-IHS services at high rates**, and often at higher cost than if they were able to access care earlier and closer to home.

The state Medicaid program pays almost twice as much for health care for Native Americans by non-IHS providers as IHS providers. For Native Americans eligible for IHS services and also Medicaid eligible, health care expenditures provided through IHS are reimbursed at 100% federal funds through Medicaid. Health care expenditures for Medicaid eligible Native Americans by a non-IHS provider are reimbursed at the state's regular FMAP (51.62% federal/48.38% state in state fiscal year 2016). For this reason it is fiscally beneficial to the state to help eligible Native Americans get care from IHS instead of non-IHS providers. Given the capacity issues with IHS, the state is looking for innovative ways for eligible Native Americans to get care that qualifies for 100% federal funding as it would if IHS were able to provide it.

The state, in collaboration with IHS and non-IHS health care provider, is specifically seeking to implement different strategies to significantly augment services that can be provided to Medicaid eligibles through 100% federal funding authority through a variety of strategies. Examples include using health care specialists available through non-IHS providers to serve patients at IHS sites via telehealth or specialty clinic arrangements. Other examples include use of telehealth emergency room services to reduce non-emergency transfers of patients from IHS to non-IHS providers in the state and the provision of clinic services in non-reservation population centers to better serve IHS eligible Native Americans. For these strategies to work there would need to be flexibility in how IHS services are defined in terms of providers and locations of services for the purposes of Medicaid reimbursement. That means CMS would pay the same match rate (100% federal) as they would today for IHS services to Medicaid eligibles, but for more services than the current IHS system can accommodate. These strategies would benefit both the current Medicaid population and the Medicaid expansion population eligible for services from IHS.

To be clear, we are not asking for fundamental changes of funding for IHS, but for CMS to work with the state to provide needed Medicaid services that can be billed at the IHS federal rate for IHS eligible individuals.

The result of increasing access to services to individuals eligible for IHS would include better health outcomes for South Dakota Native Americans. With an increase in IHS funded services through Medicaid at 100% federal funds, state general funds used now to pay for services to this population would be redirected to offset the costs of expanding Medicaid in South Dakota. That would result in coverage for 48,000 additional people in South Dakota, more than a quarter of whom are Native American.

**South Dakota Medicaid Expansion Concept Paper**  
**March, 2015**

**Summary:** Seek flexibility in federal regulations to better meet health care needs of South Dakotans currently eligible for Indian Health Services/Medicaid and expand Medicaid to all people under 138% of the Federal Poverty Level.

**Current South Dakota Medicaid program (state plan excluding long term care and Part A, B, D premiums):**

- Average monthly eligibles – 116,000
  - 68% children – 32% adults
- 35.5% are Native American
- FY14 expenditures: \$442.3 million
- FY14 expenditures for Native Americans:
  - \$204.5 million
    - \$71.2 million funded through I.H.S.- 100% federal funds
    - \$133.3 funded at state's FMAP rate

**Medicaid expansion population key demographics:**

- 48,564 newly eligible adults
  - 26,000 have incomes less than 100% FPL
  - 22,500 have incomes between 100% and 138% FPL
- Geographic differences: 28% reside in the Western part of the state, 25% in the Southeast and 18% live in Indian counties
- Estimate 27% are Native American

Table 1: Medicaid expansion costs- Traditional expansion approach

| Total Benefits and Administration | SFY 2016       | SFY 2017       | SFY 2018       | SFY 2019       | SFY 2020       | SFY 2021       | SFY 2022       | Total thru SFY2022 |
|-----------------------------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|--------------------|
| Federal and State                 | \$ 122,226,255 | \$ 286,740,878 | \$ 337,362,178 | \$ 357,709,986 | \$ 379,293,177 | \$ 402,194,280 | \$ 426,446,913 | \$ 2,311,973,668   |
| Federal                           | \$ 120,411,605 | \$ 277,738,990 | \$ 317,002,276 | \$ 332,606,195 | \$ 345,198,847 | \$ 360,100,849 | \$ 381,838,641 | \$ 2,134,897,402   |
| State                             | \$ 1,814,651   | \$ 9,001,888   | \$ 20,359,902  | \$ 25,103,791  | \$ 34,094,330  | \$ 42,093,432  | \$ 44,608,272  | \$ 177,076,266     |

**Goals:**

1. Provide better health care access to Native Americans eligible for services through IHS funded at enhanced federal match rate to offset state costs of expanding Medicaid to entire eligible population.
2. Increase health outcomes for Native Americans eligible for Medicaid in South Dakota.
3. Increase access to health care to entire expansion population in South Dakota.

**Table 2: Future funding strategy: Current Medicaid Population-Increase IHS capacity by 2021 to increase access and improve health outcomes for Native Americans. General fund savings would be repurposed to fund Medicaid expansion.**

For demonstration purposes, the following table outlines the estimated increases in IHS capacity necessary to fund the expansion population using FY14 actual expenditures for Native Americans.

| Proposal: Assume increase in spending at 10% federal for the current Native American population and reduction in spending at the regular FMAP. Utilize general fund savings to fund expansion. |                       |                       |                       |                       |                       |                       |                       |                       |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
|  | SFY 2014              | SFY 2016              | SFY 2017              | SFY 2018              | SFY 2019              | SFY 2020              | SFY 2021              | Total SFY16-SFY2022   |
| Total Expenditures for Current Native American Medicaid Population   | \$ 204,509,570        | \$ 204,509,570        | \$ 204,509,570        | \$ 204,509,570        | \$ 204,509,570        | \$ 204,509,570        | \$ 204,509,570        | \$ 204,509,570        |
| I.H.S. expenditures  | \$ 71,209,714         |                       |                       |                       |                       |                       |                       |                       |
| Regular FMAP expenditures  | \$ 133,299,856        |                       |                       |                       |                       |                       |                       |                       |
| <b>Expenditures I.H.S. 100% Federal</b>  | <b>\$ 71,209,714</b>  | <b>\$ 74,960,542</b>  | <b>\$ 89,213,490</b>  | <b>\$ 111,927,718</b> | <b>\$ 121,417,296</b> | <b>\$ 139,398,374</b> | <b>\$ 155,394,578</b> | <b>\$ 160,426,258</b> |
| Increase in I.H.S. needed to reduce regular FMAP spending  |                       |                       |                       |                       |                       |                       |                       |                       |
|  | \$ 3,750,828          | \$ 18,003,776         | \$ 40,718,004         | \$ 50,207,582         | \$ 68,188,660         | \$ 84,184,864         | \$ 89,216,544         | \$ 354,270,258        |
| <b>Expenditure Regular FMAP</b>  | <b>\$ 133,299,856</b> | <b>\$ 129,549,028</b> | <b>\$ 115,296,080</b> | <b>\$ 92,581,852</b>  | <b>\$ 83,092,274</b>  | <b>\$ 65,111,196</b>  | <b>\$ 46,114,992</b>  | <b>\$ 44,083,312</b>  |
| Federal  | \$ 69,157,120         | \$ 66,873,208         | \$ 57,648,040         | \$ 46,290,926         | \$ 41,546,137         | \$ 32,555,598         | \$ 24,557,496         | \$ 22,041,656         |
| State  | \$ 64,142,736         | \$ 62,675,820         | \$ 57,648,040         | \$ 46,290,926         | \$ 41,546,137         | \$ 32,555,598         | \$ 24,557,496         | \$ 22,041,656         |
| Reduction in FMAP spending needed to general fund savings  |                       |                       |                       |                       |                       |                       |                       |                       |
| General Fund Savings   | \$ (3,750,828)        | \$ (18,003,776)       | \$ (40,718,004)       | \$ (50,207,582)       | \$ (68,188,660)       | \$ (84,186,864)       | \$ (89,216,544)       | \$ (354,272,258)      |
|  | <b>\$ 1,814,651</b>   | <b>\$ 9,001,388</b>   | <b>\$ 20,389,002</b>  | <b>\$ 25,103,791</b>  | <b>\$ 34,094,330</b>  | <b>\$ 42,093,432</b>  | <b>\$ 44,688,272</b>  | <b>\$ 177,076,286</b> |
| General  | \$ 64,142,736         | \$ 62,675,820         | \$ 57,648,040         | \$ 46,290,926         | \$ 41,546,137         | \$ 32,555,598         | \$ 24,557,496         | \$ 22,041,656         |
| Federal  | \$ 140,366,834        | \$ 141,833,750        | \$ 146,861,530        | \$ 158,218,644        | \$ 162,963,433        | \$ 171,953,972        | \$ 179,362,074        | \$ 182,467,914        |
| Total  | \$ 204,509,570        | \$ 204,509,570        | \$ 204,509,570        | \$ 204,509,570        | \$ 204,509,570        | \$ 204,509,570        | \$ 204,509,570        | \$ 204,509,570        |
| Federal share of total expenditures  | 68.64%                | 69.35%                | 71.81%                | 77.35%                | 79.68%                | 84.08%                | 87.99%                | 89.22%                |
|  |                       |                       |                       |                       |                       |                       |                       | 78.52%                |

\*estimating FMAP @ 50/50 starting in SFY2017

### **Examples of Strategies:**

1. Use established tele-health services within South Dakota to develop services at IHS facilities to reduce transfers or utilization at non-IHS facilities. Examples include ICU and emergency room services. Outcomes include reduced cost on non-IHS services subject to state match including emergency transportation, ER, and inpatient costs and increase IHS revenues through Medicaid (100% federal).
2. Partner with IHS to develop joint venture clinics or expand existing IHS clinic services to increase access to primary and other care. Examples include embedding non-IHS physicians and services lines in IHS facilities for population specific services such as obstetrics, podiatry, and dialysis. Outcomes include reductions in preterm births, Caesarean-sections, neonatal intensive care unit admissions, inpatient admissions and travel for services subject to state match and increase IHS revenues through Medicaid (100% federal).
3. Partner with IHS to develop community health representative model to help eligible individuals access primary health care through IHS. Outcomes include better health outcomes through condition management and reduction in overall health care expenditures (100% federal).

### **Assistance needed from HHS:**

1. Credential non-IHS providers to provide services in IHS facilities in South Dakota, i.e. through a preferred network approach
2. Flexible approach to defining IHS match rate eligible services
3. Support to develop new services for IHS eligible population
4. Assistance with specific aspects of Medicaid expansion in SD:
  - a. Incentives for individuals to manage health outcomes
  - b. Premium/co-payment assessments
  - c. Enrollment into Health Homes